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ABSTRACT

In 6 years of operation, the outpatient drug free treatment program at a comprehensive youth serving agency in a mid-sized northeastern city had never performed to the funder's satisfaction, had received substantial cuts in grant awards each year, and was in danger of further budget cuts. An administrative intervention was designed to improve performance in the poorly functioning extant program. The goal of the intervention was to improve the quality and quantity of services delivered in the program, as measured by improved client retention and increased client census. Professional staff were hired, clinical training and regular clinical supervision were provided, after clear lines of authority and accountability were instituted. Recruitment of clients became a counseling staff responsibility. Length of time in program for each client was measured. Admissions, discharges, and total census were aggregated and monitored each month. Program census improved from 38% to 81% of program capacity during the life of the intervention, almost meeting the intervention objective of 85%. Client retention reached 42% during the 3 months of the project, somewhat short of the 50% goal but a significant increase over past performance. Another objective of the intervention, to develop a library of state-of-the-art materials was not achieved. Substantial planning to coordinate efforts between two agency units responsible for different aspects of implementing the intervention project was discarded after the end of the project, putting the treatment program under one unit. (Author/NB)

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PRACTICUM REPORT

Center for the
Advancement of Education
Ed.D. Program

Improving Client Census and Client Retention in an Outpatient Drug Free Treatment Program for Juveniles

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NOVA UNIVERSITY

Improving Client Census and Client Retention in an Outpatient Drug Free Treatment Program for Juveniles

By

Patrice Woeppel

Cluster 20

Practicum I Report Presented to the Ed.D. Program in Early and Middle Childhood in Partial Fulfillment of the Requirements for the Degree of Doctor of Education

Nova University

1988

AUG 26 1988

PRACTICUM APPROVAL SHEET

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Approved:

6-28-88

Date

Polly Peterson, Ph.D.

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IMPROVING CLIENT CENSUS AND CLIENT RETENTION IN AN OUTPATIENT DRUG FREE TREATMENT PROGRAM FOR JUVENILES.

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In six years of operation, the outpatient drug free treatment program at a comprehensive youth serving agency in a mid-sized northeastern city had never performed to the funder's satisfaction, had received substantial cuts in grant awards each year and was in danger of further budget cuts.

This practicum describes an administrative intervention to improve performance in a poorly functioning extant program. The goal of the practicum project was to improve the quality and quantity of service delivered in the program, as measured by improved client retention and increased client census. Professional staff were hired, clinical training and regular clinical supervision were provided, clear lines of authority and accountability were instituted. Recruitment of clients became a counseling staff responsibility. Length of time in program for each client was measured. Admissions, discharges and total census were aggregated and monitored each month.

Program census improved from 38% to 81% of program capacity during the life of the project, almost meeting the practicum objective of 85%. Client retention reached 42% during the three months, somewhat short of the 50% goal but a significant increase over past performance. A fourth objective, to develop a library of state-of-the-art materials was not achieved. Substantial planning to coordinate efforts between two agency units responsible for different aspects of implementing the practicum project was discarded after the end of the project, putting the treatment program under one unit.

CHAPTER I

INTRODUCTION

Description of Program

The problem which this practicum attempted to resolve was the consistently low client census over a period of several years in the outpatient drug free treatment program of a comprehensive adolescent services agency located in a mid-sized city in western New York State.

While the program focuses on persons 12 to 25 years of age, the writer was particularly concerned with the early age of onset of drug abuse among the population served, often as early as 7 or 8 years of age, and with reaching the 12-14 year old, the low end of the agency's age range. The earlier the age of onset and the heavier the use, the more likely the youngster is to progress to heavier drug use both in terms of frequency and substance chosen. (Dupont, 1987). Thus the earlier one reaches the client, the greater the possibility of success in cessation of drug use and enabling a return to a more normal development.

Description of the Agency

The agency services are organized into four functional units by category of service: health care, education (basic skills through GED), counseling and vocational services.

The agency began in 1973, as the expression of concern by a major university medical center for the health care of adolescents whose needs it was felt could not be met by traditional services.

From its inception, the agency received substance abuse prevention funds from the predecessor state agency to the New York State Division of Substance Abuse Services (DSAS). In FY (fiscal year) 79/80, the agency began to receive DSAS funding for treatment services as well.

The major source of funds for the agency remains DSAS, which provides 36% of the agency's overall income. This percent has consistently decreased over the years, with the agency losing $60,000 in the last fiscal year, representing 15.3% of its total funds from DSAS. The agency was slated to receive a reduction in the current fiscal year in the same amount as last year.

This $1.2 million not-for-profit corporation has 38 employees distributed among the three aforementioned service units plus administrative, finance and central support services. Within the administrative unit, there is also a development office composed of the chief executive officer (CEO) and his secretary/development assistant. The development office resulted from a reorganization last year that brought in a chief operating officer (COO) to take responsibility for all program and fiscal operations and free the CEO for fund raising. Thus agency fiscal and programmatic operations are the responsibility of the chief operating officer who reports to the chief executive officer. The writer is the COO.

The 21 member board of directors represents a variety of disciplines and some of the major corporations in the city, as well as some not-for-profit agencies, and school district personnel.

The agency prides itself on providing comprehensive services geared specifically to the 12 to 25 year old young person, on the variety of

services under one roof, the lack of a fee barrier (no client is refused service because of inability to pay), the respect for client confidentiality, the sensitivity to young people's needs, and the immediacy of service delivery.

There is a perception by some funders, including DSAS, that the agency uses funds to subsidize services other than those for which the funder has contracted with the agency.

The agncy's perception is that it has a right to use funds as it sees fit despite funder requirements; verbalized by the CEO that the agency serves kids' comprehensive needs and that funding is a problem because it is categorical.

Practitioner staff include M.D.s, consultant psychiatrist and psychologist, nurse practitioners, medical assistants, client records technician, health resource educators and an outreach worker in the health care unit (HC), teachers and teachers aides in The Learning Center (TLC), and masters level counselors, MSWs and a bachelors level caseworker in the counseling and community services unit (CC, CS).

Staff have in the past perceived the agency as a place where one comes to get experience and then move on, and in fact this has been stated to applicants at preliminary job interviews, according to many past and present staff members.

Description of the Client Population

The clients are 48% black, 5% Hispanic, Native American 1%, Asian 1%, 63% male; 39% in the 12 - 17 year age range. The major drugs of abuse are marijuana 85% at admission, 85% at discharge; cocaine 12% at admission and discharge; and alcohol is the secondary drug of abuse in 70% of clients. Fifty nine percent began to use between 12 - 15 years of age, and 10% below 12 years. Forty percent have a history of arrests at admission. Agency-wide, 88% of clients are city residents.

CHAPTER II

STUDY OF THE PROBLEM

Problem Statement

The agency has consistently remained below an acceptable level of census in its outpatient drug free treatment program since April 1985.

DSAS considers 90% of capacity to be acceptable. The program's current capacity is 105 clients, thus maintenance of a minimum census of 95 clients would meet the acceptable level. For fiscal year 85/86, the mean census was 59% of capacity, well below funder expectations.

Description of Problem

In fiscal year 86/87, the outpatient drug free treatment program's capacity was reduced from 135 clients to 105 clients, accompanied by a reduction of $60,000 in the grant award from the funder. Over the years, both the actual dollars and the percent of agency total dollars provided by DSAS have been

shrinking, due to the funder's dissatisfaction with program performance. DSAS represents 36% of agency income in the current FY.

The agency was advised by DSAS that it was in danger of losing additional dollars in this fiscal year, FY 87/88, primarily because of the continued low census. Prior to implementation of this practicum, DSAS accepted the agency's service plan designed to address the major problems underlying the low census and agreed to a six month grace period to implement the new plan and assess results. If results were not acceptable, grant award cuts would be made at that time.

Staffing Pattern:

Prior to implementation, the staffing pattern in the outpatient drug free treatment program had practitioners in other units carrying a caseload in addition to their regular job duties, according to a quota system for each unit as follows:

UNIT	STAFF PER UNIT*	TREATMENT CASES
Health Care	10	--
Learning Center	4	40
Vocational	4	27
Counseling	4 + intern	29
Community Services	1	9
Total		105

* All units are also assigned additional prevention cases.

The counseling staff had been hired for their counseling expertise. Yet only 28% of the counseling caseload in the treatment program was assigned to the counseling unit. Only the counseling unit and the community services worker

receive clinical supervision. This left 72% of treatment cases covered by staff without clinical expertise and for whom counseling was not their primary job responsibility, and 64% covered by persons receiving no clinical training or supervision.

Therein was a major philosophic difference between the agency and DSAS. DSAS considers counseling the primary service and all other services are considered support services. The agency, through its staffing pattern, was demonstrating a perception of counseling as a supplement which any practitioner could provide in addition to their regular job duties, e.g. teaching classes, providing health care or job developing; and for which neither training, formal education nor clinical supervision needed to be provided.

Staff Qualifications:

Because the agency practitioner salaries were well below parity with other agencies in the area, recruitment and retention of qualified counseling staff was a problem. This was compounded by the previously mentioned perception that staff came to

the agency to gain expertise and move on. These factors created a "brain drain" whereby the best expertise that had been developed was leaving the agency and professional productivity left with it.

The limited professional experience of counseling staff also meant that caseloads should be lower in number and balanced in terms of both level of pathology and diagnostic categories.

The use of bachelors level staff with no experience in counseling who receive little or no training, and no clinical supervision to provide counseling services in addition to regular job duties was however the most critical problem. This both stressed staff and resulted in less than optimal service to clients.

Last year, an effort was made to train all practitioners in group counseling process, in order to provide a team approach to groups and enhance the therapeutic process skills, particularly of the non-professional. Only one of the group process trained practitioners remains on staff at this time.

Staff turnover remained consistently at 45% over the previous two fiscal years. For the past five months, staff turnover has been 10%.

Analysis of Causes

Perception of Counseling:

Whether true or not, there was an oft repeated quote attributed to the CEO that "good counselors are a dime a dozen", supposedly stated in response to a compliment about the agency's counseling service given by a colleague at a major referral source.

Through September 1986, counselors, health education counselors and vocational staff, all located on the ground floor of the agency site, were responsible for cleaning and vacuuming their own offices, while all other offices in the four story building were cleaned under a contract with a maintenance corporation. The explanation was that the agency could not afford it. This situation has been remedied. It is cited here because it demonstrates an inequity that management apparently

felt was acceptable, and which counselors and vocational staff accepted or gave up on changing, although limited dollars by no means decreed that lopping off the ground floor from cleaning services was the only resolution.

Historical Evolution:

The agency evolved as an alternative to traditional services in the early 1970's. Thus the looseness of definition and program structure allowed in serving at risk substance abuse "prevention" clients felt comfortable for the agency, the CEO, the staff.

The outpatient drug free treatment program began in 1978. Rather than being identified as a discrete program with services designed to fit the client, the agency perceived it as one more source of funds to sustain the agency's programs. Thus the program's staffing pattern took the funder's identified most important service, counseling, (Part 1030.2, Commissioner's Regulations, Department of Mental Hygiene, State of New York) and provided it as an add-on delivered by unskilled, untrained personnel 72% of the time, and unsupervised 64% of

the time.

In ten years of operation, this program has never performed to the funder's satisfaction, according to the funder's representative, and does not have the respect of funder, colleagues in the field, nor some staff.

During the preceding three fiscal years, the agency received cuts in grant awards totalling $100,000 from DSAS. During the same period of time, an agency for which DSAS states that it has high regard received increases totalling $200,000 from DSAS.

A 43% administration and support cost was charged to the DSAS program compared to a total agency administration and support cost of 27% last year. At the same time practitioner staff had two jobs per staff person in order to provide services in the program.

An analysis of administrative and support costs showed 33% administrative cost attributable to the development or fund raising function, which is spread across the cost of agency programs, rather

than covering its own costs plus generating additional revenue. This became part of the high administrative cost to the DSAS treatment program, that reduced the dollars available for provision of services.

Client Retention:

Client retention is related to counseling competence, i.e. it is a measure of the skills and knowledge of the counselor to be able to establish rapport and engage the client in the counseling process. Hiring practices, training, clinical supervision, job duties, salaries, and staff morale all have an impact on client retention.

Between January 1, 1986 and October 31, 1986, the treatment program had a mean census of 72.8 persons or 69.3% of capacity. During this same period, 179 persons were discharged; 98% of them without completing treatment, 62% within three months. Most discharges occurred due to lack of contact: many clients did not return again after intake. For the year ending 9/30/86, percents of cocaine, marijuana and alcohol use (major drugs abused by agency clients) were the same or higher at

discharge, than on admission.

Client Recruitment:

The agency's Learning Center (TLC) had always been the agency's major source of treatment clients. However, the total reliance on this one source for treatment clients had demonstrated its ineffectiveness. It may be that many clients who are heavy users of drugs, or drugs in combination with alcohol are not likely to present themselves for a four day a week, 3 hour per day school or tutorial program. This perception of the TLC as the source of clients does however fit with the at-risk prevention client with which the agency is comfortable.

However the early age at onset of drug/alcohol use evidenced by many young clients, indicated we needed to target our efforts elsewhere, particularly if to reach the 12 - 14 year old, the early end of the agency's age range.

Recruitment efforts by counseling staff with outside agencies were hampered by staff fears that there wouldn't be qualified staff to provide

services once the clients were referred.

Additionally, the agency's poor reputation among colleagues in the substance abuse field, as well as other provider agencies, hampers prevention funded agencies, city police department youth officers or hospital detox units from referring to the agency for outpatient treatment services. Recruitment efforts were severely hampered because of a persistent belief that the chief executive officer was still "pulling the strings" despite the presence of a chief operating officer, responsible for agency operations.

Summary:

Appendix A, Chart of Agency's Current Problems, 3/87, shows the assumed relationships between the variables outlined herein. The arrows coming from the top of the page indicate the writer's uncertainty as to how the top two items, i.e. "too few counselors..." and "all direct service staff expected to counsel..." evolved.

The disproportionate use of funder dollars for administration; the inadequate staffing pattern; the

lack of clinical expertise, training and supervision; the agency perception of itself and of counseling all contributed to the low census and poor client retention which this practicum sought to improve.

Review of the Literature

In relating the literature to the problem, the author attempted to focus on three areas: client retention, client recruitment and program content and design.

Vaglum (1985) did a follow-up study of 100 male and female drug abusers aged 15 to 26 years, treated at a hospital-based therapeutic community in Oslo, Norway. Of those who stayed over three months, 51% became drug free. By contrast, the less than three month group showed a 29% drug free rate.

Friesen (1983) cites Tims that in general the improvement rate for substance abusers remaining in any treatment modality after 2 years is 90%. However, the number of adolescents and

preadolescents that would remain in treatment for two years is likely to be exceedingly small.

Friedman and Beschner (1985) cite Sills and Simpson's 4 - 6 year follow-up study of 5405 drug treatment admissions of under 20 year olds. "Retention rates and percentage of treatment completions were best....in the outpatient drug free environment, particularly for whites and those 17 and under." However, Sills and Simpson caution that the focus was not on the use of marijuana and alcohol, the heaviest and one of the heaviest drugs of abuse respectively among adolescents and preadolescents.

In Hubbard, Cavanaugh, Craddock and Rachal's study in Friedman and Beschner (1985) of 1,042 clients under 20 years in outpatient non-methadone and residential programs, 62 - 65% had dropped out of treatment in the outpatient drug free programs within 13 weeks. This figure is roughly comparable to our agency's drop out rate within the same period. However the study cohort excluded programs specifically designed for younger people.

In the Northwest Youth Outreach Program, in

Chicago, an outpatient drug free program geared to adolescents, the formal program lasts 30 - 36 weeks, followed by 4-6 months of "aftercare". (Kusnetz in Friedman and Beschner, 1985).

A thirty five to 40 % successful termination rate is claimed, although youngsters often enter and re-enter the program many times before completing. Similar to the agency, the primary drugs of abuse in the Northwest Program are alcohol and marijuana. The racial composition of the program is more heavily white (75%) than that of the agency.

Simpson (1981) describes a study of 1,496 persons admitted to a variety of outpatient substance abuse treatment modalities over a two year period and followed up 6 - 7 years later.

Those who stayed less than three months fared not significantly differently from those who received no treatment at all. Breakdown ofthis group into 1-30 days, 31-60 days, and 61-90 days showed no relationship between difference in tenure in program and posttreatment outcomes.

However, beyond three months, Simpson found a linear relationship between length of time in treatment and positive outcomes which could not be accounted for by differences at time of admission.

An additional factor to be considered in treatment appears to be age at onset of drug use. The earlier the age of onset and the heavier the use, the more likely the client is to progress to heavier drug use both in terms of frequency and substance chosen. (Dupont, 1987).

Hubbard, Cavanaough, Craddock and Rachal's study cited in Friedman and Beschner (1985) was the one reference to recruitment found in the literature. Except for 18 and 19 year old females (40%) , half or better of all referrals to outpatient drug free programs were either the result of family and friends or the criminal justice system. Schools accounted for almost 20% of those 17 and younger. Self referrals ranged from 8.5% to 22%.

If to improve client outcomes and client retention, how should a program be designed? Here the literature was less than satisfactory, being primarily anecdotal and descriptive. The author also attempted to limit the scope of this phase of the literature search to outpatient drug free programs which is the modality the Agency is certified by the state to provide.

Khuri, Millman, Hartman, and Kreek (1984) caution that alcoholism is a critical problem among youthful substance abusers and former substance abusers in methadone maintenance programs. More significant for its implications for treatment is their concern that individual treatment may pose a barrier to the peer support that facilitates successful treatment. Vaglum (1985) posits that the most fragile substance abusers may make an easier emotional link to the group than to an individual, at least initially.

Friesen (1983) finds that family therapy is quite appropriate for adolescent substance abusers with high family involvement and family stress.

Kaufman and Borders (1984) detail the

characteristics of certain types of ethnic American families and the implications for treatment of a substance abusing adolescent within such a family system.

Shapiro (cited in Friedman and Beschner, 1985) describes a comprehensive service for adolescents, after which the agency is patterned. According to Shapiro, The Door treats drug problems by "responding to the problems and needs identified by adolescents themselves", not necessarily focusing on drugs.

Shapiro identifies five phases of treatment: denial, recognition, directive action, self-initiated action, and autonomy. On Shapiro's scale, most agency clients aren't getting past Phase II and many are lost in Phase I.

Although most of the services described for The Door are very similar to those offered at the Agency, the difference seems to be in the structure; e.g. counseling services are provided by the counseling unit at The Door. At the Agency, everyone is a counselor, one of the major areas that

was changed by the practicum implementation.

The literature on children of substance abusers focused heavily on withdrawal of addicted newborns, on infancy and on development of mother-child attachment (Deren, 1986).

In the area of program content and design several program descriptions were found in Kusnetz (cited in Friedman and Beschner, 1985). Family issues in relation to treatment implications found in Kaufman and Borders (1984) provided valuable information in program planning, design and implementation.

In general, the literature was less than satisfactory, particularly in the areas of client retention and client recruitment. References to treatment of young substance abusers were few. Many of the references found were from research projects looking at the data from a large number of programs treating young abusers in the same program with adults or related to other modalities of treatment, i.e. inpatient/residential or outpatient methadone maintenance treatment programs.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals

The goal of the project was to improve the quality and quantity of service delivered in the Agency's substance abuse treatment program, as measured by increased client retention and increased client census.

A new staffing pattern, consistent with both DSAS (funder) requirements and standards of good counseling practice, was implemented.

A sufficient number of personnel with knowledge of counseling practice and a solid theoretical framework was hired.

Training to maintain and upgrade skills was provided.

Regular ongoing clinical supervision was provided.

A library of state-of-the-art materials was to have been developed to keep staff abreast of changes in the field and stimulate clinical thinking and problem-solving.

Recruitment of treatment clients was expected to be hampered no longer by the perception that there would not be enough qualified staff to provide services once new clients were intaked.

Because counseling expertise would have improved, the counselor's ability to establish rapport and engage the client in the counseling process was expected to improve, and to have a positive impact on client retention.

Skilled counseling practice resulting from theoretical grounding plus ongoing clinical supervision and in-house training would improve the counselor's ability to contract with the client on agreed-upon short term objectives and would improve the client's ownership and achievement of objectives.

Objectives

1. To provide clinical training and regular ongoing clinical supervision to all staff providing counseling services beginning in month one of the project.

2. To increase client census to 89 youngsters (85% of capacity) by the end of the third month.

3. To retain a minimum of 50% of clients in treatment three months or longer by end of third month, as evidenced by admission, discharge data.

4. To develop a library of state-of-the-art materials for staff development by the end of third month of the project.

Evaluation Instruments

The Ph.D. clinical psychologist's weekly appointment book and schedule were used as verification of clinical supervision.

The attendance list provided documentation of participation in the five day training entitled

Training in Short Term Client Systems Counseling was provided on the agency's site by the Narcotics Research and Training Institute of the State Division of Substance Abuse.

The agency's extant statistical system was utilized as much as possible. Thus, retention rates were determined from a comparison of the agency's monthly client master list against preceding months intake rosters. The agency's monthly statistical reports show total beginning and ending census and admissions and discharges for the preceding month.

Discharges are aggregated by the number of months in program at time of discharge. For all discharges that month, the percents discharged within one month, two months, three months or more were tallied and compared with previous months as well as the three month period prior to implementation of the practicum. This data did not exist for the same period in the prior year.

Minutes from counseling unit team meetings were expected to contain brief synopses of the reports by team members as a documentation of the literature being utilized for staff development. Copies of

paid invoices for materials ordered and received by the Agency was the simplest measure of the presence of journals, and other staff development materials in a library.

In sum, the agency's extant statistical system provided most of the evaluation instruments. Attendance sheets and schedules were developed as needed.

CHAPTER IV

SOLUTION STRATEGIES

Possible Solutions

Certainly one solution to the agency's treatment program census problem would have been to close the treatment program. However, the immediate fiscal impact on the agency would have been disastrous.

Another solution would have been to do nothing. This inaction could be predicted to lead to another budget cut of at least $60,000 based on past history.

The program could have been redesigned as an intensive full day program, called "day treatment" in the DSAS taxonomy, and have attempted to carve out a niche in the treatment continuum. However, DSAS would have been unwilling to approve either an

increased budget or the same budget to serve fewer clients, given the long standing problems that it had identified with the Agency.

There did not appear to be strong indications in the literature that day treatment is any more successful than other modalities with young substance abusers.

Other methods of providing outpatient treatment to young substance abusers were examined both in the community and as reported in the literature. (Friedman and Beschner, 1985; Beschner and Friedman, 1985; Friesen, 1983; Vaglum, 1985). Outpatient programs (OPDs) can be structured loosely or intensively, for greater or less frequency, and for a single activity (counseling) or a variety of activities. Counseling staff can be professional or non-professional or some combination of the two.

Because the youngsters the agency serves are generally at the beginning /intermediate stages of dependency, the writer chose a moderately structured model of one to four times/week clinic visits and access to a variety of services, including education and health care. Staffing was provided by both

professional and non-professional persons, with counseling provided only by professionals. Intake, screening and orientation preceded the provision of services.

Actual Program

The setting was an outpatient drug free treatment program with counseling at its core and offering educational remediation and high school equivalency preparation, coupled with vocational, health care and health education services. All services were delivered at the same site in a central, public transportation-accessible midtown location. Satellite locations at two city junior-senior high schools and one high school were also targeted.

The subjects were juveniles identified as evidencing drug usage to point of dependency and/or disruption of one or more life activities, or deemed appropriate for OPD level of care and admitted to the Agency's drug free treatment program. There were 89 subjects at the end of the project period.

The counseling staff were also subjects of this

project in relation to the training and supervision objectives. All counseling staff were masters level counselors or M.S.W.s assigned a caseload of treatment clients either at the Agency or school sites.

In order to adequately perform the client recruitment, intake and counseling functions necessary to maintain a census of 105 clients, the following staff were hired/assigned to the project:

Position	% FTE
Clinic Coordinator	0.5
Counselors	4.0
Clinical Psychologist	0.2
Psychiatrist	2 hrs./mo.,
add.time as needed	
Intake Coordinator	0.5

Report of Action Taken

Phase 1: Secure Support

Before the program could be implemented, it was

necessary to secure support among a variety of key stakeholders (Borg and Gall, 1983): the funder,DSAS; the community through the County Community Mental Health Board and its Substance Abuse Committee; the Board of Directors of the agency; agency CEO; staff; and ultimately clients.

Despite the continuing precarious position of the Agency with its major funder, historically the image the Agency had held of itself, and that is reflected in the Agency name and its literature is of an "alternative" to traditional services, rather than as a professional specialized service with expertise in service to young persons.

The Community Mental Health Board and its Substance Abuse Committee approved the project plan and its attendant budget.

The funder representative approved the plan with a flat budget projection at the same level as last year. He was quick to point out that while his support was behind the plan he wanted to see results or the Agency would continue to be cut as it has in the past.

Over a period of many months, the Personnel and the Program/Medical Committees of the agency's board were apprised of the agency's problems with the major funder and the manifestation of these problems in personnel, program and budget. Both committees supported the proposed plan before the full board. The full board acted in support of both plan and budget.

There was much discussion over many months between the chief executive officer and the chief operating officer with respect to the proposed plan. Its acceptance by the CEO was probably more the result of being the least objectionable of the identified alternatives than any perceived intrinsic merit of the plan.

Staff in all operating units of the agency were supportive of the plan.

The counseling unit was initially very committed to the plan, recognizing it as an opportunity to provide a better service, while being anxious about its newness. Later, the staff's anxiety began to escalate. Administration provided reassurance and support , along with regularly

scheduled problem-solving meetings between the two units with responsibility for carrying out the program, counseling and the Learning Center (TLC). Staff were supported in their own ability to resolve problems in the implementation process among themselves.

Some health care staff had expressed the view that the agency does not know how to provide drug treatment services so maybe it should not. But there was general agreement that if we were going to do so, then we should provide a quality service. This unit also had been very concerned about the lack of clinical supervision and accountability for much of the counseling that the agency provided.

The third unit, The Learning Center (TLC), was pleased that they would no longer be responsible for counseling 110 treatment and prevention clients, along with their teaching duties. However, there remained much anxiety over a perceived loss in status of this unit once counseling became the core service, manifested by a verbalized desire to be professional counselors also. An additional concern that control of intake would no longer emanate from this unit was resolved by the unit leaders'

participation in the hiring of the Intake Coordinator and a continuous close working relationship thereafter, including involvement in decision-making on intake-related issues.

Historically, The Learning Center (TLC) had been viewed as the elite unit. Prior to implementation, reports from directors of ther units described their frustration with trying to jointly plan, operate cooperatively, or to integrate select activities between TLC and their units, leaving a perception that the TLC operated independently from the rest of the Agency.

Recognizing both the past history and problems of the TLC, along with the importance of their acceptance and participation, both Counseling and TLC were encouraged to work jointly on the specifics of the plan prior to its targeted implementation date. Those meetings, begun on an as needed basis, were institutionalized and occurred on a regular basis throughout implementation, assuring the support of both units.

Phase 2: Preparation for Implementation

In preparation for a redesigned treatment program to solve the problems identified in Chapter II, many discussions between the COO and the clinic coordinator were held over a period of time. Several meetings and one retreat were also held to generate ideas and receive feedback between counseling staff and the coordinator. Additional meetings between the coordinator and the psychologist consultant were also taking place simultaneously to both generate and reflect on ideas, concepts and to assure a workable clinical plan capable of engaging and retaining our young clients and of assuring counseling staff receptivity and capability.

Once the counseling unit was comfortable with the plan, it was presented to the funder (DSAS) and simultaneously to the County by the COO. Internally, it was then shared with other unit directors at the leadership staff meeting and presented at a full staff meeting and within each unit at unit staff meetings, so that the concepts could be aired and any problems or issues be opened up for discussion.

Thus the detailing of how the plan would be operationalized required mutual airing of the issues and meeting the needs of clients, TLC and counseling. There was a natural synergistic relationship between the two units with respect to some of the treatment clients, in that they came for an educational service and were then found to need treatment.

Phase 3: Client Recruitment

Client recruitment took place in preparation for and following implementation of the new plan. Counseling staff went out into the community to talk about the new program. Some specific client groups were targeted:

Through a United Way grant, the agency provided treatment services on site at three junior and senior high schools using a curriculum developed by the clinic coordinator and a former staff member.

Youth officers assigned to each precinct within the City Police Department met with the clinic coordinator around a plan to begin to make

referrals.

Phase 4: Implementation

Recruitment and hiring of staff:

New counselors were recruited and hired for July/August starting dates.

Supervision:

Prior to the beginning of the project, only 28% of treatment cases were assigned to staff receiving clinical supervision.

Administrative Supervision: Once per week supervision with the counseling coordinator (clinic coordinator) around case assignments, case coverage, chart notes and assigned duties was provided for all staff involved in the project.

Team meetings were held once per week with the counseling coordinator and all counseling component staff. As part of this project, a portion of each meeting was to be devoted to a review of the

literature, with each counselor being assigned a journal article to read, review, and report on a rotating basis.

Clinical Supervision: Each counselor in the project met individually one hour per week with the Ph.D. clinical psychologist consultant for clinical supervision.

Each counelor in the project met in group 1 1/2 hours every other week for supervison in coleading therapeutic groups.

Training:

Three counselors and one intern received a one week intensive training in Short Term Client Systems Counseling from September 28 - October2, 1987.

Weekly resource team meetings and once monthly case conferences chaired by the consultant psychiatrist continued throughout.

Develop a Library of Materials:

A library of state-of-the-art materials to keep

staff abreast of changes in the fields of substance abuse treatment, child development, and counseling practice was anticipated to be developed to enhance professional development.

Intake and Orientation for Clients:

Prior to the implementation of the practicum, clients were sometimes served for a month or more without having been intaked, and for many more months before being identified as a treatment client. The hiring of an experienced intake coordinator, knowledgable about substance abuse, became an important element in the early identification of treatment cases, as well as set the pace with the client for the newly implemented structure. This was especially true for former agency clients who were used to a very loose and undemanding program.

As part of the newly designed program, clients were expected to attend two orientation sessions: The first was an introduction to the agency's services, the second was a drug education session. Clients were introduced to their assigned counselors

at this session, and their rights, responsibilities and mutual expectations were set forth.

The author anticipated that the initial laying out of the ground rules and expectations would eliminate some clients up front, while enhancing the agency's chances of retaining those that remained, because they would be better informed and know what to expect.

CHAPTER V

RESULTS, CONCLUSIONS AND DISSEMINATION

Results

Objective 1. To provide clinical training and regular on-going clinical supervision to all staff providing counseling services beginning in month one of the project.

Three of the four treatment counselors plus a field placement intern and all of the Learning Center staff attended the five day training in Short Term Client Systems Counseling brought to the agency the last week in September. This training set the stage for a short term client contracting approach to therapy in synchrony with the therapeutic approach of our consultant clinical psychologist.

Regular weekly individual and bi-weekly group clinical supervision was provided by the agency's consultant clinical psychologist for all counselors throughout the project implementation and thereafter. However, six treatment clients (7%) continued to be counseled by Learning Center staff who did not receive clinical supervision. In those six cases, it was agreed by both the counseling unit and TLC that it would not be in the best interests of the client to transfer to a counselor. Since

January, 1988, the TLC staff have received clinical supervision, and will continue to do so until July when it is expected that TLC staff will no longer counsel any clients.

Objective 2. To increase client census to 89 youngsters (85% of capacity) by the end of the third month.

The projected census of 89 youngsters (85% of capacity) was reached by the end of the third month of the project. On July 31st, just prior to the beginning of the project on August 1st, the program census was 40 clients, or 38% of capacity. (see Table 1).

Client recruitment became an expected job function for each counselor and the intake coordinator. The intake coordinator came to the agency with many contacts in the community from her previous position, and this proved extremely beneficial in establishing trust on the part of some referring agencies. These efforts contributed greatly to the improved census as the agency began to become less reliant on The Learning Center for its clients. Our school-based counseling services

in four schools also contributed to the increase.

However, the agency continues to be unsuccessful with the police department youth officers and some other community providers. The writer had been aware of the agency's poor image among community providers and colleagues, but had underestimated its magnitude. The youth officers and the family services team within the police department had a very strong negative history with the agency and its leadership, and although they could see positive changes, they bluntly stated that as long as the old leadership was still present they felt the changes would not last: there had been positive changes before and when people left the changes vanished also.

Objective 3. To retain a minimum of 50% of clients in treatment three months or longer by the end of the third month.

Of the 38 clients in the program on July 31, 1987, 42% remained in the program three months later on October 30th. This is not the 50% projected but demonstrates an improvement over past performace wherein the program would have turned over 75% in

that period of time.

Of the 58 clients in the program on August 31, 1987, 27 (46.6%) remained in the program on November 30th, representing a 4.5% gain in retention over the previous month's three month retention figure.

Most clients were being lost in the intake/orientation process, and thus the highest discharge figures were in the first month. It appeared that once the client was engaged in the treatment process, discharges dropped significantly. However, on almost all comparative measures with the preceding three month period, significant reductions in discharges were noted. (see Table 2).

Data such as the length of time in program at time of discharge did not exist for the same period in 1986, thus we compared the three months of the implementation against the preceding three months on several measures to assess progress toward the objective. (see Table 2).

Discharges as a percent of total census were reduced by more than half. The smallest improvement was in the reduction in the percent of discharges

within the first month, (17%). This pattern has continued beyond the practicum implementation. In reviewing the specific cases, those clients who come in crisis do not return. The agency still treats the crisis at the initial visit but now reschedules the intake for a later visit. Whether this will result in improved retention is not yet known. It will, however, save intake and statistician time in opening and closing cases that are seen only once.

Discharges appear to increase again at four or more months and this pattern has persisted before, during and after the practicum. For this and other reasons, following the practicum, the agency reviewed the program and increased the structure. (see Appendix B).

Discharges at 2, 3, and 4 or more months showed significant decreases during the practicum, demonstrating an improved ability to retain clients. One and a half months following the end of the practicum, a DSAS site visit revealed that some cases had been held open although the contacts had not been made. Of that total, four cases would have

affected the census during the period of the practicum, thereby reducing the 85% census to 81%, somewhat below the objective.

The writer examined all client records of persons admitted and/or discharged during one month, August 1987, to see whether any loss-associated characteristics could be determined. Race; sex; age; age at onset of drug use; major drugs of abuse, including alcohol; level and frequency of drug usage, including alcohol; source of referral and whether source of referral was contacted. Only the latter factor, i.e. whether source of referral was contacted, appeared preliminarily to be an early indicator of client discharge for loss of contact.

Five clients were referred by an outside agency. Two out of two clients (100%) in which the referring agency was not contacted were lost at initial contact. Only one out of three clients (33.3%) in which the referring agency was contacted was lost. The numbers are too small, however, to be significant.

The writer also compared the admissions and discharge rates in the drug abuse prevention program

also operated by the agency with those in the treatment program for the same period (see Table 3) and with the treatment program for the same period in the preceding year (Table 4).

While there was a consistent pattern from year to year, the percent of discharges over admissions was significantly lower over the period of the practicum (43.5% compared to 64.4%). Was there some other explanation beyond the practicum intervention that could account for the improvement? If so, a comparison of the agency's prevention program, which was not part of the practicum, with the treatment program for the same period should show a comparable improvement. It did not. (see Table 3). Discharges as a percent of admissions were significantly lower in month 2 and 3 for the treatment program, although not in month 1.

Thus on all measures, the program's retention rate improvements were validated.

The overall pattern of discharges, however, over the three months for treatment as well as for prevention and the comparison with the treatment program for the same period in the preceding year

all show an increase. Thus while both the numbers and percents of discharges decreased, the comparative climb in discharges from month 1 to month 3 is an indicator that retention may have improved but the problem is still present.

Objective 4. To develop a library of state-of-the-art materials for staff development by the end of the third month of the project.

Within the time frame of the project, this objective was not accomplished. Materials were identified, but neither ordering, nor receipt occurred and the proposed assignment and discussion of relevant journal articles did not take place. The importance of this objective is still recognized. It is expected that after project implementation and operation have stabilized, this objective can be fulfilled.

Conclusions

Following the end of the practicum, the program census continued to climb, reaching 103, 98% of capacity, by November 30th. However, as mentioned previously, this figure did not hold up on audit. Five months later the census is at 80%. The pattern of the heaviest drop out (discharge) rate in the

first month and significant decline in discharges in months 2 and 3 have continued.

As a result of the practicum process and analysis, the agency continues its client recruitment efforts with the police department's youth officers and juvenile probation, both because of the early age at onset of drug abuse for many clients (some as young as 7 or 8 years of age) and the leverage provided by both systems that the author believes maximizes the potential to keep the client engaged in the treatment process long enough to have a positive impact.

The practicum results indicated that the program was on the right track but more was needed. The agency's efforts to create a cooperative working relationship and joint responsibility for different aspects of the treatment program between TLC and the counseling unit has been discarded. After seven months lead time and six months of implementation, The Learning Center was still spending substantial time and energy defending its ability to counsel, and too little time expanding its teaching repertoires, improving curricula and materials and enforcing established standards for students' attendance and behavior. This situation

increasingly hampered the counseling unit's ability to implement a structured treatment program for clients who were also in TLC.

As a result, The Learning Center will be operated separately from the DSAS treatment and prevention programs beginning July 1, 1988. This decision enables the unit to concentrate on its identity as a school.

Following the practicum the program became more structured, improving on its beginning during the practicum. A parent or significant other is now required to participate in the program along with the client. When an outreach worker left the agency, it provided the opportunity to hire a family therapy consultant to both train counselors in family therapy and run a family therapy group. These changes are still very new.

The director of counseling has expressed concern about increasing anxiety noted among some counseling staff members. The writer recently dropped in on a group supervision meeting and discovered that the counseling staff have steered that meeting to the safer administrative issues and

have not been using it to discuss clinical problems and concerns. The new program design is heavily group-focused. As new groups are formed and counselors do not feel secure or growing in their group skills, anxiety could heighten. The clinical psychologist has been instructed to focus on clinical issues, steering administrative issues to the appropriate persons and meetings.

The position of intake coordinator was a new one for the agency. The intake coordinator was the conduit through which treatment clients entered the agency and she also controlled assignment to the counseling staff in an expeditious manner. The position and the expertise of the person in it proved invaluable to the program, both in the early identification of substance abuse problems and the level of care required by each young client and in the establishment of a credible relationship with referring agencies. Over a recent three week period, the agency had 31 outside referrals from community agencies for the treatment program.

Dissemination

Portions of this practicum have been shared with the counseling and TLC staff, particularly the retention and census figures on a regular basis.

The full report will be shared with the funding agency. That agency is in a position to determine the extent of applicability of the practicum experience for other adolescent and pre-adolescent serving agencies. The author is also considering writing an article for publication based on the management strategies employed during the planning phase that assured sufficient support for implementation despite a CEO who opposed the plan.

The funder, DSAS, has recognized the gains made and although the agency is not yet consistently meeting their census requirements, has agreed to an extension until December 31, 1988. For the second year in a row, the agency did not receive a budget reduction from the funder, as it had in past years.

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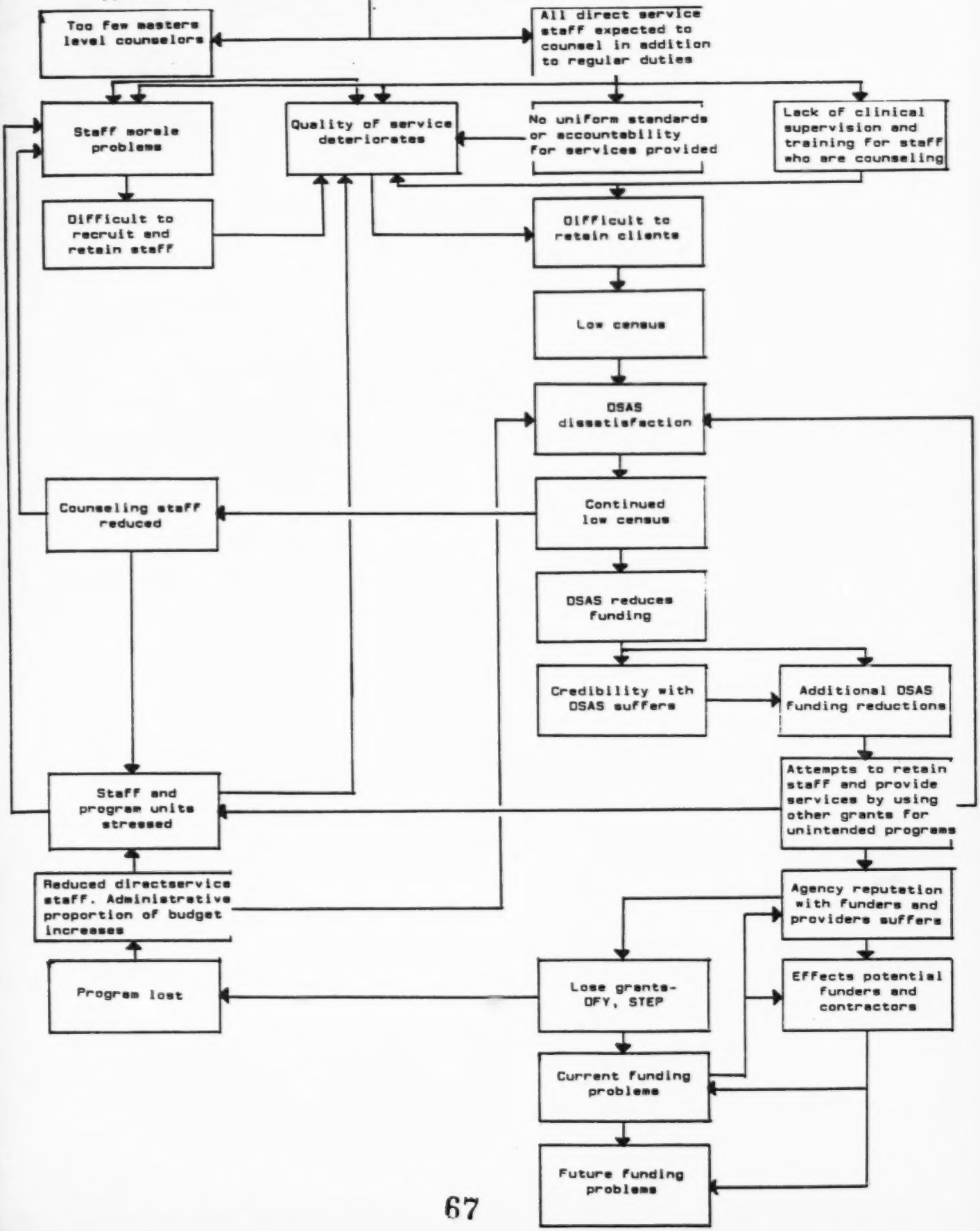
APPENDIX A

Chart of Agency's Current Problems, 3/87

Appendix A Flow Chart Agency's Current Problems 3/87


Too few masters level counselors
All direct service staff expected to counsel in addition to regular duties
Staff morale problems
Quality of service deteriorates
No uniform standards or accountability for services provided
Lack of clinical supervision and training for staff who are counseling
Difficult to recruit and retain staff
Difficult to retain clients
Low census
OSAS dissatisfaction
Counseling staff reduced
Continued low census
OSAS reduces funding
Credibility with OSAS suffers
Additional OSAS funding reductions
Staff and program units stressed
Attempts to retain staff and provide services by using other grants for unintended programs
Reduced directservice staff. Administrative proportion of budget increases
Agency reputation with funders and providers suffers
Program lost
Lose grants- OFY, STEP
Effects potential funders and contractors
Current funding problems
Future funding problems

APPENDIX B

Revised Treatment Program Design

PROGRAM PROFILE

provides outpatient treatment services for adolescents and young adults between the ages of 12 to 25 years. The program can serve 105 persons whose substance use range from use/abuse to dependency.

DRUG ABUSE PATTERN:

Marijuana, alcohol, cocaine.

SERVICE AREA/REFERRAL SOURCES:

Clients come to through self referral, schools, other community agencies, and the criminal justice system. The service area is the city of Rochester and surrounding suburbs.

REQUIREMENTS:

-A willingness to work on substance issues

-A willingness to commit themselves to the duration of the program.

-A willingness to have family and/or significant others involved in treatment.
OR
if mandated by the criminal justice system.

FEE STRUCTURE/FUNDING:

Clients pay based on a sliding fee scale determined by their financial situation. No one is turned away because of inability to pay. The NYS Division of Substance Abuse Services is the primary funding source.

PROGRAM DESCRIPTION:

The program accepts substance abusers and chemically dependent persons. Clients requiring detoxification and inpatient treatment are referred elsewhere for services.(See attached chart).

Clients are in the program for approximately 6-8 months. Primary services include individual, group counseling, group therapy and family counseling. Job skill development, educational services, health education, community services and health services are offered as support services. The eighteen (18) week group counseling sessions include a problem-solving, decision-making, skill-building, educational and support approach.

In the fourth and fifth stages of treatment, clients receive fourteen (14) weeks of group therapy aimed towards an emotional rational cognitive interaction to effect change. A total of 18 sessions of individual counseling is offered. Families or significant others are required to participate for at least three (3) family therapy sessions and four informational group counseling sessions. The support services are offered at different stages of the treatment (See Stages of Treatment Chart).

SERVICES OFFERED

Individual Counseling
Group Counseling
Group Therapy
Family Therapy
Job Skill Development
Educational Instruction
Health Education
Health Services
Community Services

TYPES OF GROUPS NEEDED

Stress Management
Adolescent Development
Decision-making/Problem-solving
E.P.I.C.
Education in chemical use/abuse
Self Image
Therapy group
Support group
Tough Love

TABLE 1

Treatment Program Census, July through October 1987

DATE	NO. CLIENTS	% CAPACITY
JULY 31	40	38
AUG. 31	58	55
SEPT. 30	85	81
OCT. 31	89	85

TABLE 2

63

Outpatient Drug-Free Treatment Program Totals, Three Month Means and Comparisons of Three Month Means. Outpatient Drug-Free Treatment Program End of Month Totals; Mean Totals; Total Discharges and as Percent of End of Month Totals; and Discharges at 1,2,3 and 4+ Months and Respective Percent of End of Month Totals for May through July 1987 compared to August through October 1987, and Percent Reduction in August through October 1987.

MONTH	END OF MONTH TOTALS	TOTAL DISCHARGES	DISCHARGES AS % OF TOTALS	DISCHARGE 1 MONTH	%	DISCHARGE 2 MONTHS	%	DISCHARGE 3 MONTHS	%	DISCHARGE 4+ MONTHS	%
MAY 87	59	10	16.9	4	6.7	2	3.4	0	-	4	6.7
JUNE 87	48	10	20.8	2	4.2	2	4.2	3	6.3	10	20.8
JULY 87	40	20	50.0	7	17.5	5	12.5	2	5.0	6	15.0
MEAN 5/87-7/87	49		29.2	13	26.5	9	18.4	5	10.2	20	40.8
AUGUST 87	58	2	3.4	0	-	0	-	1	1.7	1	1.7
SEPTEMBER 87	85	16	18.8	10	11.8	1	1.2	1	1.2	4	4.7
OCTOBER 87	89	20	22.5	7	7.9	2	2.2	1	1.1	10	11.2
MEAN 8/87-10/87	77.33		13.7	17	22.0	3	3.9	3	3.9	15	19.4
% Reduction 8/87-10/87 over 5/87-7/87			53.1		17		78.8		61.8		52.5

TABLE 3

Number of Discharges and Admissions, and Discharges as a percent of Admissions by month from August through October 1987 in both the Outpatient Drug-Free treatment and Drug Abuse Prevention Programs.

	TREATMENT		PREVENTION	
DATE	Discharges/Admissions	%	Discharges/Admissions	%
AUGUST 87	2/20	10	0/24	-
SEPTEMBER 87	16/43	37.2	40/43	93
OCTOBER 87	20/24	83.3	30/25	120

TABLE 4

Comparison of Admission and Discharge Totals between August through October 1986 and August through October 1987 in the Outpatient Drug-Free Treatment Program.

	1986				1987		
DATE	ADMISSIONS	DISCHARGES	D/A %	DATE	ADMISSIONS	DICHARGES	D/A %
AUGUST 86	29	3	10.3	AUGUST 87	20	2	10
SEPTEMBER 86	31	21	67.7	SEPTEMBER 87	43	16	37.2
OCTOBER 86	13	15	115.3	OCTOBER 87	24	20	83.3
MEAN			64.4				43.5